

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05152  
166

5158

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>GARRETT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>WILLIAM</b>	Middle <b>TURNEY</b>	Last <b>DE WEESE</b>	4. DATE OF DEATH Month <b>MAY - 21</b>	Month <b>1956</b>	Day	Year
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY-30-1900</b>	9. AGE (in years, last birthday) <b>95 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GASOLINE DISTRIBUTOR.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>ERWIN PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES DE WEESE</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET SPIEGEL.</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. W.T. DE WEESE OAKLAND MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> INTERVAL BETWEEN ONSET AND DEATH 420.1 IMMEDIATE DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <b>Hypertensive Cardio-Vascular Disease</b> 4 YEARS DUE TO (c) <b>Myocardial Infarction OLD</b> 6 YRS.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) ADDRESS (Street, city or town, state)	(County) (State)
21. I certify that I attended the deceased from <b>4-18</b> , 19 <b>50</b> , to <b>5-21</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>5-21</b> , 19 <b>56</b> , and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>James H. Feaster Jr.</b> M.D. 58 2nd St. Oakland, Md 5-22-56 PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR., M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAY-23-1956</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>MEMORIAL WESTMORELAND CEMETERY</b>		22d. LOCATION (City, town, or county) <b>GREEN BURG Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Emory Bolden</b>		ADDRESS <b>OAKLAND MD.</b>		24a. REC'D. BY REGISTRAR DATE <b>5/22/56</b>		24b. REGISTRAR'S SIGNATURE <b>Julia H. Roark</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

CERTIFICATE OF SERVICE

BUREAU V.I.

MAY 25 1956

KLEGEVÉ

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05153  
166

5159

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakland		c. LENGTH OF STAY IN 1b 71 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakland		d. STREET ADDRESS 10 Mi. N W Oakland		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10 Mi. N W Oakland, Md.				d. STREET ADDRESS 10 Mi. N W Oakland				
3. NAME OF DECEASED (Type or print)		First Theodosia	Middle Friend	Last DeWitt	4. DATE OF DEATH May 30,	Month 1956	Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 17, 1885	9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Zadok Friend		14. MOTHER'S MAIDEN NAME Alice Friend						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Mrs. Peder Baasland		Address Oakland, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) <i>Arteriosclerotic Heart Disease</i> } DUE TO (c) <i>Debility.</i>						INTERVAL BETWEEN ONSET AND DEATH 4 hrs		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>4-28-57</i> , 19 to <i>5-25</i> , 19, that I last saw the deceased alive on <i>4-28</i> , 19, and that death occurred at <i>8:55P</i> M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>58 2nd St. Oakland, Md.</i>		
ACTUAL SIGNATURE <i>Jas. H. Feaster, Jr.</i>						DATE SIGNED <i>5-3-57</i>		
PHYSICIAN'S NAME (Type) Jas. H. Feaster, Jr.						Oakland, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/2/1956		22c. NAME OF CEMETERY OR CREMATORIUM Hoyes Run Cemetery		22d. LOCATION (City, town, or county) Garrett County, Md.		(State)
22e. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert C. Leighton</i>		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE 6/2/56		24b. REGISTRAR'S SIGNATURE <i>Julia A. Roway</i>		

CERTIFICATE OF DEATH

FEDERAL BUREAU OF INVESTIGATION  
RECEIVED

JUN 6 1956

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any doubt is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 5160 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05154

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland c. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Swanton		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM EDWARD DURST		First	Middle
4. DATE OF DEATH Month MAY Day 3 Year 1956	Last	Month	Day
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1873
9. AGE (in years last birthday) 83 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm	
11. BIRTHPLACE (State or foreign country) Garrett Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hanson Durst		14. MOTHER'S MAIDEN NAME Charlotte Broadwater	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none 17. INFORMANT Mrs Pearl Durst, Swanton R.D. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED 5/3/56	
ACTUAL SIGNATURE E. J. Baumgartner EXAMINER'S NAME (Type) E. J. BAUMGARTNER		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/6/56 22c. NAME OF CEMETERY OR CREMATORIALY Dry Run	
22d. LOCATION (City, town, or county) Garrett Co., Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Donald J. Newman		24a. REC'D BY REGISTRAR Grantsville, Md.	24b. REGISTRAR'S SIGNATURE A. H. Hedrick
		DATE 5/14/56	

BUREAU Y. E

MAY 14 1956

REGELIVE

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05155

5161

## CERTIFICATE OF DEATH

Reg. Dist. No.

9

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE				
Garrett MARYLAND		Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finzel		c. LENGTH OF STAY IN 1b				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First	Middle			
GRACE		M.	EISLER			
4. DATE OF DEATH		Month	Day Year			
May 27, 1956						
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> female white WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) 50 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
				7-1-1905		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME				
Lloyd A. Arnold		Susan Baker				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  I		16. SOCIAL SECURITY NO.		17. INFORMANT		Address
(If yes, give war or dates of service)		none		Sam H. Eisler,		Finzel, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Ch. myocarditis - atherosclerosis				INTERVAL BETWEEN ONSET AND DEATH 3 wks
443x Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) DUE TO (c) DUE TO		Cardio renal vascular disease with severe hypertension				30 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
19						
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on May 27, 1956, and that death occurred at 1:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE J. R. Durst, M.D. ADDRESS (Street, city or town, state) 36 Green St. Crisfield, Md. DATE SIGNED						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-30-1956		22c. NAME OF CEMETERY OR CREMATORIAL Greenville Cemetery		22d. LOCATION (City, town, or county) Greenville, Pa. (State)
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 5-30-56		24b. REGISTRAR'S SIGNATURE Mrs. Nancy N. Ross

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be submitted within 24 hours after death: Page 4 may be referred by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF REGISTRATION

REGISTRATION STATE OF HAWAII - MARCH 1956

BUREAU V. S.

JUN 4 1956

REGISTERED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5162

## CERTIFICATE OF DEATH

0515866  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Garrett</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Sang Run</b>		c. LENGTH OF STAY IN 1b <b>82 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Sang Run</b>		d. STREET ADDRESS <b>one mile east Sang Run</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>one mile east Sang Run</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Alfred</b>		First <b>Ira</b>	Middle <b>Friend</b>	Los <b>7</b>	4. DATE OF DEATH <b>May 7, 1956</b>	Month <b>May</b>	Day <b>7</b>	Year <b>1956</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 4, 1874</b>	9. AGE (In years less birthday) <b>82 yrs.</b>	IF UNDER 1 YEAR <b>Months</b>	IF UNDER 24 HRS. <b>Days</b>	IF UNDER 24 HRS. <b>Hours</b>	IF UNDER 24 HRS. <b>Min.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John F. Friend</b>		14. MOTHER'S MAIDEN NAME <b>Rachel Friend</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. -----		17. INFORMANT <b>John F. Friend, Jr. Sang Run, Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>Sclerotic Heart Disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>First attack</b>		
(b) DUE TO <b>Senility</b>						<b>Years</b>		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>58 2nd St.</b>		20f. (City or town) <b>Oakland, Md.</b>		(County) <b>Oakland</b> (State) <b>Md.</b>
21. I certify that I attended the deceased from <b>6-19</b> , 19 <b>53</b> , to <b>4-4</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>4-27</b> , 19 <b>56</b> , and that death occurred at <b>11:50 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>JAMES H. FEASTER, JR., M.D.</b>						ADDRESS (Street, city or town, state) <b>Oakland, Md.</b>		DATE SIGNED <b>5-8-56</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/10/1956</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>J. F. Friend home Cem.</b>		22d. LOCATION (City, town, or county) <b>near Sang Run, Md.</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Herbert C. Leighton</b>		ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR <b>5/10/56 Julia A. Ronan</b>		24b. REGISTRAR'S SIGNATURE <b>ZR</b>		
VS AIS (4) 15M 9/55								

RECEIVED  
FBI - NEW YORK

155  
MAY 17 1956  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

BUREAU V. 8

MAY 17 1956

RECEIVED

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5163 CERTIFICATE OF DEATH

05157

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Garrett</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Accident</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Accident, Md.</b>		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)		First <b>ANNA</b>	Middle <b>ELIZABETH</b>	Last <b>GEORG</b>	4. DATE OF DEATH <b>May 17</b>	Month <b>May</b>	Day <b>17</b>	Year <b>19 56</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> Nov. 11, 1867</b>	8. AGE (In years last birthday) <b>88 yrs</b>	9. IF UNDER 1 YEAR Months <b>88</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	11. BIRTHPLACE (State or foreign country) <b>Mill Run, Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>August Frederic</b>		14. MOTHER'S MAIDEN NAME <b>Neil</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT	Address				
		<b>none</b>	<b>Raymond Georg, Daisytown, Pa.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<b>Chronic Myocarditis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>
{ Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) DUE TO		<b>Arteriosclerosis</b>						<b>10 years</b>
{ } (c) DUE TO <b>Diabetes</b>								<b>4 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m.      19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Friendsville, Maryland</b>	(County) <b>Garrett Co., Md.</b>	(State) <b>Md.</b>		
21. I certify that I attended the deceased from <b>May 16, 1956</b> to <b>May 17, 1956</b> that I last saw the deceased alive on <b>May 17, 1956</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>M.D. no# Maple St., Friendsville, Maryland</b>						DATE SIGNED
ACTUAL SIGNATURE <b>Milton Tepfer</b>								
PHYSICIAN'S NAME (Type) <b>Milton Tepfer, M.D.</b>		Friendsville, Maryland May 19, 1956						
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/20/56</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Zion Lutheran</b>		22d. LOCATION (City, town, or county) <b>Accident, Garrett Co., Md.</b>			(State) <b>Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Donald J. Newman</b>		ADDRESS <b>Grantsville, Md.</b>	24a. REC'D BY REGISTRAR <b>MAY 21 1956</b>		24b. REGISTRAR'S SIGNATURE <b>J. H. Hedrick</b>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician signed by the attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

May 3  
N.O.

Afternoon  
visitors  
etc

94

1000

May 10 2000

Afternoon

May 10

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5164

## CERTIFICATE OF DEATH

05159

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>STAR Route, Frostburg, Md.</b>		c. LENGTH OF STAY IN 1b <b>10 YRS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BETTY JEAN LICHTY</b>		First	Middle
4. DATE OF DEATH <b>MAY 2 1956</b>		Last	Month
S. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>MAY 15, 1933</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WORK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Family Home</b>	11. BIRTHPLACE (State or foreign country) <b>GRANTSVILLE, Md</b>
13. FATHER'S NAME <b>EARL LICHTY</b>		14. MOTHER'S MAIDEN NAME <b>LEOSHA BUTLER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>multiple pulmonary abscesses</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic bilateral bronchiectasia</b> DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 30, 1956</b> , to <b>May 2, 1956</b> , that I last saw the deceased alive on <b>May 1, 1956</b> , and that death occurred at <b>5:45 P.M.</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>A. Paige Strong</b> M.D. ADDRESS (Street, city or town, state) <b>Salisbury, Penna</b> DATE SIGNED <b>5/3/56</b> PHYSICIAN'S NAME (Type) <b>A. PAIGE STRONG</b> SALISBURY, Pa			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/6/56</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>MT ZION</b>		22d. LOCATION (City, town, or county) (State) <b>STAR Route, Frostburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Donald J. Newman</b>		ADDRESS <b>GRANTSVILLE, MD</b>	
24a. REC'D BY REGISTRAR DATE <b>7 1256 A. St. Hedrich</b>		24b. REGISTRAR'S SIGNATURE <b>J. B. Hedrich</b>	

BUREAU V. S

MAY 7 1962

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05160

## 5165 CERTIFICATE OF DEATH

Reg. Dist. No.....

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** This law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS C 1-55 (OM)

<b>1. PLACE OF DEATH</b>			<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>		
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	Garrett MARYLAND LENGTH OF STAY (In this place) 15 yrs		STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	Maryland COUNTY Garrett 166 Rural Oakland	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Sunnyside		STREET ADDRESS	(if rural give location) Sunnyside	
<b>3. NAME OF DECEASED</b> (First) James Robert LUDWIG			<b>4. DATE OF DEATH</b> May 23, 1956		
S. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH Sept. 20, 1872	9. AGE last birthday 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal miner			10b. KIND OF BUSINESS OR INDUSTRY Coal	11. BIRTHPLACE (State or foreign country) Rio, West Va.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Phillips George Ludwig			14. MOTHER'S MAIDEN NAME Elizabeth Oats		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. None	17. INFORMANT & ADDRESS Lee Ludwig, Baltimore, Md.		
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>					
450.0 IMMEDIATE CAUSE (A) <i>Arterial Heart Disease</i>					
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerosis</i>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Age</i>					
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>					
19a. DATE OF OPERATION <i>May 1956</i>		19b. MAJOR FINDINGS OF OPERATION		19c. INTERVAL BETWEEN ONSET AND DEATH	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
<b>22. I hereby certify that I attended the deceased from ..... 19 ..... to ..... 19 ..... , that I last saw the deceased alive on ..... May 23, 1956, and that death occurred at ..... 11:30 A.M. from the causes and on the date stated above.</b>					
<b>SIGNATURE</b> <i>J.W. Mengel</i> M.D.					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF May 27, 1956		NAME OF CEMETERY OR CREMATORIAL Odd Fellow Cem.	
24. REC'D BY REGISTRAR DATE May 24/56		REGISTRAR'S SIGNATURE <i>Julia J. Kenon Jr.</i>		LOCATION (City, town, or county) Elk Garden, W. Va.	
<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>J.D. Duncan</i> ADDRESS <i>John D. Duncan Thomas, W. Va.</i>					

BUREAU V. S

MAY

DEPARTMENT OF

05161  
Reg. Dist. No. 0566

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**5166 CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY CLARK MONTGOMERY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE WEST VIRGINIA		b. COUNTY Preston		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TERRA ALTA		d. STREET ADDRESS ROUTE 3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SARATOGA COUNTY MEDICAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First ASA	Middle RAY	Last SISLER	4. DATE OF DEATH MAY 14 1956	Month MAY	Day 14	Year 1956
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 11, 1896	9. AGE (In years lost birthday) 59 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARTER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) TERRA ALTA, W. VA.		12. CITIZEN OF WHAT COUNTRY? UNITED STATES		
13. FATHER'S NAME ISAAC CLINTON SISLER		14. MOTHER'S MAIDEN NAME S. RAH SMITH						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 236-03-9004		17. INFORMANT Mrs. Ethel May Sisler, Terra Alta, W. Va.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162X		DUE TO Mild hypertension		2		days		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost		(b) Myocardial infarction		2		days		
		(c) Cerebral hemorrhage		11		days		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Terra Alta		(County) (State)
21. I certify that I attended the deceased from <u>May 13, 1956</u> , to <u>May 14, 1956</u> , that I last saw the deceased alive on <u>May 13, 1956</u> , and that death occurred at <u>9:42 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Ethel May Sisler</u>						ADDRESS (Street, city or town, state) M.D. Terra Alta, W. Va.		DATE SIGNED 5/15/56
PHYSICIAN'S NAME (Type) Char. E. Smith, M. D.				Territory, West Virginia				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 17, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Terra Alta Cemetery		22d. LOCATION (City, town, or county) Terra Alta, W. Va.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE P. R. Watson, Terra Alta, W. Va.		ADDRESS		24a. REC'D BY REGISTRAR DATE 5/16/56		24b. REGISTRAR'S SIGNATURE Helen Rowan LR		

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU

MAY 25 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5167 CERTIFICATE OF DEATH

05162

Reg. Dist. No.

166

1. PLACE OF DEATH a. COUNTY  GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE  WEST VIRGINIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town  OAKTON D.		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  CLERK TTT COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)  WILLARD		First VOG. J. R. S. SMITH	Middle
4. DATE OF DEATH MAY 29 1956		Month	Day Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 24, 1870
9. AGE (In years from birthdate) 86 yrs		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) F. L. J.		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME SAMPSON SMITH		14. MOTHER'S MAIDEN NAME SUSAN SMITH CARR. Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) nd		16. SOCIAL SECURITY NO.	
17. INFORMANT TRACY SMITH			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4/22/56 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH  Chronic heart failure Chronic myocarditis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic bronchitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 12, 1956, to May 29, 1956, that I last saw the deceased alive on May 29, 1956, and that death occurred at 4:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE S. B. Bevins, Jr. PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) M.D. 252 Cedar St Belleville (Marlboro)	
22a. BURIAL-CREMATION REMOVAL (Specify) June 2, 1956		22b. DATE THEREOF Smith Family Cemetery	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State) Mayesville W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Blaine Schaeffer - Petersburg		24a. REC'D BY REGISTRAR DATE 7 1956	
		24b. REGISTRAR'S SIGNATURE Julia Rawles	

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**TO HOSPITAL** may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be held with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1805163

Item 9 Film 1951

5168

## CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY <b>Garrett</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>5 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crellin</b>		d. STREET ADDRESS <b>Box 74</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garrett County Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>Nute</b>	Middle <b>Sam</b>	Last <b>Stiles</b>	4. DATE OF DEATH <b>May 1 1956</b>	Month <b>May</b>	Day <b>1</b>	Year <b>1956</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 2, 1889</b>	9. AGE (In years last birthday) <b>66 1/2 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. HOURS Hours <b>0</b>	13. MIN. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired COAL MINER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>			
13. FATHER'S NAME <b>La Fayette Stiles (Deceased)</b>		14. MOTHER'S MAIDEN NAME <b>Harriett Garby (Deceased)</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address <b>Mrs. Nute S. Stiles, Box 74, Crellin, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Congestive heart failure 10 days?</i>					
(b)		DUE TO							
(c)									
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>4/30/56</b> to <b>5/1/56</b> , that I last saw the deceased alive on <b>4/30/56</b> , and that death occurred at <b>11:03 AM</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>Thomas &amp; Lusby, N.D.</b>		DATE SIGNED <b>5/1/56</b>			
ACTUAL SIGNATURE <i>Thomas &amp; Lusby</i>									
PHYSICIAN'S NAME (Type) <b>THOMAS &amp; LUSBY</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAY 5-1956</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>ASHBY CEMETERY</b>		22d. LOCATION (City, town, or county) <b>NEAR CRELLIN MD.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Emroy Bolden OAKLAND MD</i>		ADDRESS		24a. REC'D BY REGISTRAR <b>Julie A. Powers</b>		24b. REGISTRAR'S SIGNATURE			
				DATE <b>5/1/56</b>					

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5169

## CERTIFICATE OF DEATH

0516466  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Md.		b. COUNTY Garrett		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park, Md.		c. LENGTH OF STAY IN 1b 6 mon.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park, Md.		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in Hospital, give street address) OR INSTITUTION Layson Nursing Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) HOWARD		First	Middle	Last	4. DATE OF DEATH May 13	Month	Day	Year 1956
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1879		9. AGE (In years last birthday) 76 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) woodsmen		10b. KIND OF BUSINESS OR INDUSTRY cutting posts		11. BIRTHPLACE (State or foreign country) Grantsville, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Issac Swauger				14. MOTHER'S MAIDEN NAME Virginia Layman				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Charles Swauger, Grantsville, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  440.1		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Coronary Occlusion Coronary Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 week 5 yrs		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Oakland, Md.		20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____ P.M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Oakland, Md.	DATE SIGNED	
ACTUAL SIGNATURE ARTHUR F. JONES								
PHYSICIAN'S NAME (Type) ARTHUR F. JONES								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/16/56		22c. NAME OF CEMETERY OR CREMATORIUM New Germany Reformed		22d. LOCATION (City, town, or county) Grantsville, R.D. Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Donald F. Newman	ADDRESS Grantsville, Md.		24a. REC'D BY REGISTRAR DATE 5/16/56		24b. REGISTRAR'S SIGNATURE Gates Brown			

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5170

## CERTIFICATE OF DEATH

05165 66  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) b. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ESTELLA</b>	First <b>FRANTZ</b>	Middle <b>SWEENEY</b>	Last <b>MAY - 26 1956</b>
4. DATE OF DEATH <b>MARCH - 7 - 1884</b>	Month <b>72 yrs</b>	Day <b>IF UNDER 1 YEAR IF UNDER 24 HRS</b>	Year <b>Months Days Hours Min</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARY 7 1884</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SELBYSPORT MD</b>	
11. BIRTHPLACE (State or foreign country) <b>MARY DUNHAM.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>EDWARD FRANTZ</b>		14. MOTHER'S MAIDEN NAME <b>MARY DUNHAM.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>PERCY FRANTZ OAKLAND MD</b>	
17. INFORMANT <b>DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. <b>Myocardial heart disease</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>Coronary Heart Disease</b> → PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial heart disease</b> → DUE TO <b>Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b>	
19. WAS AUTOPSY PERFORMED? <b>NO</b>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Month, Day, Year Hour o. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Oakland</b>		20f. (City or town) (County) (State) <b>Oakland</b>	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <b>A. E. France</b> M.D. ADDRESS (Street, city or town, state) <b>Oakland, Md 27 May 1956</b> DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>A. E. France</b>		22b. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	
22c. DATE THEREOF <b>MAY-29-1956</b>		22d. NAME OF CEMETERY OR CREMATORIUM <b>OAKLAND CEMETERY</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Emrys Bolden</b>		24e. LOCATION (City, town, or county) (State) <b>OAKLAND MD</b>	
ADDRESS <b>OAKLAND MD</b>		24f. REG'D BY REGISTRAR DATE <b>5/29/56</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5171

## CERTIFICATE OF DEATH

05166 6

Reg. Dist. No.

**TO HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death; Page 4 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MT. LAKE PARK</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>DALE M. COUNTY MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>BOX 18A</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JOHN L. TEAGARDEN</b>		First <b>J.</b>	Middle <b>T.</b>
4. DATE OF DEATH <b>MARCH 23-1887</b>		Month <b>APR</b>	Day <b>25</b>
5. SEX <b>M</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 23-1887</b>	
9. AGE (In years from birthdate) <b>69 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	
11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MINISTER</b>		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) <b>OHIO</b>		11. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>JOHNSON TEAGARDEN</b>		14. MOTHER'S MAIDEN NAME <b>EMMA WISE.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MRS. MABLE TEAGARDEN</b>		Address <b>MT. LAKE PARK</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b>		<b>Cerebral embolism</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		<b>1/2 days</b>	
(b) DUE TO <b>Cerebral heart disease</b>		<b>1 year</b>	
(c) <b>Altered sclerosis</b>		<b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1956</b> to <b>May 25</b> , 1956, that I last saw the deceased alive on <b>May 25</b> , 1956, and that death occurred at <b>4:30</b> P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Oakland Md</b>	
ACTUAL SIGNATURE <b>Andrew E. Francis</b> M.D.		DATE SIGNED <b>26 May 56</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAY-28-1956</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>EGDON CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>EGDON</b> <b>WVA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Emory Bolden</b>		24a. REC'D BY REGISTRAR DATE <b>5/26/56</b>	
ADDRESS <b>OAKLAND MD</b>		24b. REGISTRAR'S SIGNATURE <b>W. R. Rowan</b>	

BUREAU V. A.

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**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

5172

**CERTIFICATE OF DEATH**

05167

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>							
COUNTY <b>Garrett</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Garrett</b>					
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		STREET ADDRESS (If rural give location)					
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Shady Mill, Garrett Co.		Shady Mill, Garrett Co.		Star Route, Frostburg, Maryland					
Star Route, Frostburg, Md				Star Route, Frostburg, Maryland							
<b>3. NAME OF DECEASED (Type or Print)</b>				<b>4. DATE OF DEATH</b>							
(First) <b>WILLIAM</b> (Middle) <b>LEWIS</b> (Last) <b>TURNER</b>				May 24, 1956 19							
S. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.				
Male	White	Widowed	June 29, 1869	86	Yrs.	Months	Days	Hours	Mins.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dairyman</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
				Own Dairy		Garrett County, Maryland			U S A		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
JOSUA TURNER				ELIZA GURLEY							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>NO</b>				16. SOCIAL SECURITY NO.				17. INFORMANT & ADDRESS			
				None				Star Route, William Turner, Frostburg, Maryland			
<b>18. MEDICAL CERTIFICATION</b>										INTERVAL BETWEEN ONSET AND DEATH	
<p><b>420.0 IMMEDIATE CAUSE</b> (A) <i>Chronic myocardial degeneration</i></p> <p><b>ANTECEDENT CAUSE(S)</b> DUE TO (B) <i>Atherosclerotic heart disease</i></p> <p><b>DISEASES OR CONDITIONS, IF ANY,</b> GIVING RISE TO THE ABOVE CAUSE <b>STATING UNDERLYING CAUSE LAST.</b> DUE TO (C) <i>Generalized atherosclerosis</i></p>										5 years	
										10 years	
										10 yrs	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>											
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
None											
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)				21c. WHERE DID INJURY OCCUR? (City or town)				(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?							
<b>22. I hereby certify that I attended the deceased from <i>April 2, 1956</i>, to <i>May 23, 1956</i>, that I last saw the deceased alive on <i>May 2, 1956</i>, and that death occurred at <i>11:30 A.M.</i>, from the causes and on the date stated above. SIGNATURE <i>A. Paige Strong</i> M.D. ADDRESS (Street, city, town, state) <i>Frostburg Penna. May 24, 1956</i> DATE SIGNED <i>May 24, 1956</i></b>											
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>May 26, 1956</b>		NAME OF CEMETERY OR CREMATORIUM <b>Trinity EV. Ref. Cem</b>		LOCATION (City, town, or county) <b>Garrett County, Maryland</b>				(State)	
24. REC'D BY REGISTRAR <b>May 26, 1956</b>		REGISTRAR'S SIGNATURE <i>M. H. Hendrich</i>		25. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Md.</b>						ADDRESS	

DEPARTMENT OF STATE  
RECEIVED IN THE LIBRARY OF THE HOUSE OF REPRESENTATIVES

THE LIBRARY OF CONGRESS

BUREAU V. S.

MAY 29 1950

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5173

## CERTIFICATE OF DEATH

05168/6

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b>		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE <b>MARYLAND</b>		b. COUNTY <b>GARRETT</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MT. LAKE PARK.</b>		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>FLAVIOUS</b>	Middle <b>JOSEPH</b>	Last <b>TURNEY</b>	4. DATE OF DEATH Month <b>MAY - 25</b>	Year <b>1956</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL-9-1878</b>	9. AGE (In years last birthday) <b>78 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>FRIENDSVILLE MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>ISAAC TURNEY</b>		14. MOTHER'S MAIDEN NAME <b>NANCY JANE MEYERS</b>		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-10-3616</b>		17. INFORMANT <b>JOSEPH TURNEY</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINO - a</b> OF NECROSIS 191X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-Sclerotic Heart Disease</b> DUE TO (c) <b>Years</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>OAKLAND</b>		20f. (City or town) (County) <b>OAKLAND MD.</b>	(State) <b>MD.</b>	
21. I certify that I attended the deceased from <b>7-18</b> , 19 <b>49</b> , to <b>5-25</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>5-25-56</b> , 19 <b>56</b> , and that death occurred at <b>10:15 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Jean H. Lester Jr.</b> ADDRESS (Street, city or town, state) <b>OAKLAND MD.</b> DATE SIGNED <b>5-28-56</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAY-28-1956</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>OAKLAND CEMETERY</b>		22d. LOCATION (City, town, or county) <b>OAKLAND</b> (State) <b>MD.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Emory Bolden</b>		ADDRESS <b>OAKLAND MD.</b>		24a. REC'D BY REGISTRAR DATE <b>5/28/56</b>		24b. REGISTRAR'S SIGNATURE <b>Julia H. Powers Jr.</b>		

CERTIFICATE OF DEATH

RECEIVED  
BUREAU X-5  
JUN 6 1956